

Nigerian farmers rejoice in pilot insurance plan

A Dutch-supported foundation is 'exporting' private health insurance to Nigeria, selling a US\$ 30 health-care package for US\$ 3. Gary Humphreys reports.

In Kwara state, a poor agricultural district in western Nigeria, health insurance is a rarity. Like 70% of Nigerians, most people survive on less than one dollar a day. If they visit the doctor at all, they have to pay out of their own pockets. However, this grim situation recently changed for one group of farmers.

They are not covered by Nigeria's National Health Insurance Scheme (NHIS), which despite being set up more than a decade ago, still only serves 3.73% of the population (civil servants working for the Federal government and in Bauchi and Cross River states, and 300 000 women and children under the Maternal and Child Health Project). Nor are they one of the seven million or so Nigerians, of a total population of 148 million, who can afford to pay for private health insurance. The 35 000 farmers and their dependents are in fact the beneficiaries of a scheme put together by PharmAccess, a Dutch government-backed, not-for-profit organization that supports HIV/AIDS treatment and what it describes as "general health-care projects" in developing countries.

In Nigeria, PharmAccess is supporting the idea of private health insurance, which it is delivering through the Health Insurance Fund (HIF), a foundation set up to pilot low-cost private health insurance, which includes HIV/AIDS care and treatment for low- to medium-income groups in sub-Saharan Africa.

HIF includes among its backers The World Bank and the United States Agency for International Development (USAID) – institutions that take an interest in applying

private health insurance 'solutions' to health financing problems in developing countries. The Dutch also have a strong commitment to private health insurance in their national system. So in a sense they are 'exporting' their know-how. HIF's local partner is Hygeia, a health management organization (HMO). Hygeia is one of Nigeria's largest HMOs with a network of more than 250 clinics and hospitals.

On the face of it the HIF scheme is puzzling. After all, how can people earning less than a dollar a day pay for the kind of insurance that would give them access to, for example, comprehensive maternal health care? The answer is they don't.

Establishing precisely how much they could or would pay was one of the research goals set by Emma Coles, HIF's director. "There really is no data on this," she says. "So we look at peoples' income. We also look at what they are already spending out of pocket, which roughly matches what they are willing to pay."

According to World Health Organization statistics, total health expenditure in Nigeria is around US\$ 33 per capita, 63.4% of which comes directly out of pocket. This suggests that the farmers of Kwara state might be ready to spend around US\$ 20 annually – or slightly less given the poverty of the region.

In fact, the farmers were reluctant to pay anything like this amount. Indeed, since 2007, Hygeia has been offering the farmers a health-care package comprising comprehensive primary health care and limited secondary health care, including up to five days of hospitalization, and maternal health care (including caesarian section) – a health-care package that HIF prices at US\$ 30 a year – for slightly less than US\$ 3.

So who pays the US\$ 27 balance? According to Coles, HIF is picking up the tab for the time being. Needless to say, this raises questions about the applicability of the term 'private health insurance' in this case, and also highlights sustainability issues. According to Coles, one solution for sustainability is the support of the Kwara state government. "The state governor has refurbished three public hospitals within the scheme, has committed to co-finance its expansion of the scheme and will take over

the subsidies over a five-year period," she explains, pointing out that this is a matter of contractual commitment by state governor Dr Abubakar Bukola Saraki.

Whether that contractual commitment will ultimately be honoured is questioned by some. Dr Tolu Ayangbaya, a health economist formerly with the Nigerian Ministry of Health, for example, says, "In five years' time, the person who promised [to pay the subsidy] today will not be in the government. So who are you going to hold accountable?"

“If the insurance isn't offered to identifiable groups that can share health risks, you run the risk of adverse selection.”

Emma Coles

Coles is also hopeful that consumers will start paying more of the premium as they begin to appreciate the advantages of prepayment and see what they are getting for their money. According to Dr Abayomi Sule, programme coordinator of the Hygeia Community Health Plan in Nigeria, attitudes are already changing. "Initially people did not understand the prepayment concept but over time we have educated them," he says. "We say it is a community scheme. If they don't use it, their neighbour will."

According to Dr Peju Adenusi, chief executive officer of the Hygeia Community Health Plan, the farmers have been delighted with what they get for their money. "Utilization in one clinic has jumped from 16 people per month before the programme was started to 1500 people per month afterwards," she says. One woman was so grateful for the life-saving Caesarian section she received that she named her baby boy Hygeia.

To be fair to HIF, it needs to be pointed out that, just because people are not paying a lot for the care they receive, does not mean that quality shouldn't be



Beneficiaries show their health insurance cards in Kwara state, Nigeria.



People line up for a health insurance card in Afon, Kwara state, Nigeria.

rewarded. After all, the farmers can choose which clinic or hospital they walk into and, although they are only paying \$3 dollars, the clinic or hospital then bills Hygeia for the care dispensed. Theoretically at least, this provides an incentive to give quality service. According to Coles, PharmaAccess has seen a substantial increase in the quality of the clinics which it measures every six months.

However, it is questionable whether such demand-side stimulus changes much in the context of Kwara state, where, according to Adenusi, a handful of clinics and three hospitals serve a population of around three million people. Moreover, as pointed out by Adenusi herself, the Hygeia Community Health Plan operates as a monopoly in Kwara state. The farmers don't really have much choice.

They are not alone in this. Despite there being 42 HMOs in Nigeria, consumer choice is generally left out of the equation. "Part of the problem in Nigeria is that HMOs tend to be granted a state monopoly as part of a contract with NHIS," explains Dele Abegunde, a Nigerian health economist working with WHO's Essential Medicines and Pharmaceutical Policy Department. "There's a kind of free market approach inherent in the NHIS choice for managed care insurance approach but, because of peculiarities on the ground, the principles of competition are not applied and the benefits elude the consumers," he says. Abegunde also points out that many Nigerian HMOs typically rake 15% off the top. This attracts a lot of players, including financial institutions such as banks, which have neither the skills, professional

mandate nor training for operating managed care.

Neither PharmAccess nor HIF make any claim to solving Nigeria's health financing problems, but they do hold out the hope of incremental improvement by addressing what is arguably Nigeria's biggest health financing challenge – the extension of health insurance coverage to nongovernment workers. Abegunde estimates that around 90% of the total workforce is engaged in informal employment of this kind – whether in casual or freelance work or agricultural labour. Not visible on payrolls or tax returns, nongovernment workers are notoriously difficult to 'capture' in insurance schemes which are generally based on documentation of one kind or another.

HIF offers a way into the informal sector by targeting specific groups for coverage. It doesn't really matter what the group is as long as it can be readily identified. Cole explains: "If the insurance isn't offered to identifiable groups that can share health risks, you run the risk of adverse selection." In other words, the service offered would be overwhelmed by the sick and elderly, while the healthy and young would tend to stay away.

In the United Republic of Tanzania, where HIF has just launched a second pilot programme, it is working with people with micro-loans from a local financial organization and is also developing a programme for coffee farmers in the Kilimanjaro region. The approach makes sense within the terms of what HIF is trying to achieve but, from a broader health policy perspective, it leaves key challenges unmet. What happens to all the people who can't be easily grouped, for example?

No-one is going to blame HIF for excluding people from what is, after all, a pilot scheme, but there are issues with this kind of targeted approach nevertheless. For Abegunde, the problem is that ultimately the whole population needs help and thus excluding anyone, no matter what the reason, should not occur. "We need national policy and national oversight," he says. "We need solutions that work for the population as a whole."

For Ayangbaya the problem of targeting is compounded when virtually all of the funding comes from outside. "You're giving the Kwara state government a five-year break from their responsibilities – from what they ought to be doing themselves," he says. ■



Nurses at the official launch of the health insurance programme in Afon, Kwara state, Nigeria.